FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031765

Facility Name: BRIAR PLACE LTD.

Address: 6800 W JOLIET ROAD (Number) INDIAN HEAD PK (City) 60525 (Zip Code)

County: COOK

Telephone Number: (708) 246-8500 **Fax #** (708) 246-0086

IDPA ID Number: 363472799001

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,560	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,377	2,328	4,050	27,755	8
9	SNF/PED					9
10	ICF	41,496	4,728	276	46,500	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	62,873	7,056	4,326	74,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.69%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1485

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	308,901	41,903	22,098	372,902		372,902	(9,033)	363,869			1
2	Food Purchase		266,908		266,908		266,908	3,296	270,204			2
3	Housekeeping	189,580	48,256		237,836		237,836	2,309	240,145			3
4	Laundry	116,650	25,173		141,823		141,823		141,823			4
5	Heat and Other Utilities			205,646	205,646		205,646	3,059	208,705			5
6	Maintenance	157,364		189,896	347,260		347,260	(12,540)	334,720			6
7	Other (specify):*							2,604	2,604			7
8	**TOTAL General Services**	772,495	382,240	417,640	1,572,375		1,572,375	(10,306)	1,562,069			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,788,937	98,402	193,042	2,080,381		2,080,381	(25,880)	2,054,501			10
10a	Therapy	53,659	1,122	19,525	74,306		74,306	2,781	77,087			10a
11	Activities	114,154	10,503	6,366	131,023		131,023	(1,380)	129,643			11
12	Social Services	152,400		7,423	159,823		159,823	(4,911)	154,912			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							13,656	13,656			15
16	**TOTAL Health Care and Programs**	2,109,150	110,027	235,356	2,454,533		2,454,533	(15,734)	2,438,799			16
	C. General Administration											
17	Administrative	27,629		65,781	93,410		93,410	55,729	149,139			17
18	Directors Fees											18
19	Professional Services			370,018	370,018		370,018	(344,119)	25,899			19
20	Dues, Fees, Subscriptions & Promotions			119,795	119,795		119,795	(45,635)	74,160			20
21	Clerical & General Office Expenses	126,333	18,094	165,482	309,909		309,909	25,057	334,966			21
22	Employee Benefits & Payroll Taxes			633,493	633,493		633,493	(31,246)	602,247			22
23	Inservice Training & Education			2,773	2,773		2,773	(805)	1,968			23
24	Travel and Seminar			2,269	2,269		2,269	1,617	3,886			24
25	Other Admin. Staff Transportation			47,845	47,845		47,845	(29,888)	17,957			25
26	Insurance-Prop.Liab.Malpractice			312,473	312,473		312,473	1,567	314,040			26
27	Other (specify):*							32,435	32,435			27
28	**TOTAL General Administration**	153,962	18,094	1,719,929	1,891,985		1,891,985	(335,288)	1,556,697			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,035,607	510,361	2,372,925	5,918,893		5,918,893	(361,329)	5,557,564			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIAR PLACE LTD. #0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			118,853	118,853		118,853	178,959	297,812			30
31	Amortization of Pre-Op. & Org.			3,075	3,075		3,075	1,678	4,753			31
32	Interest			41,305	41,305		41,305	885,332	926,637			32
33	Real Estate Taxes			276,292	276,292		276,292	4,439	280,731			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(936,438)	6,092			34
35	Rent-Equipment & Vehicles			8,463	8,463		8,463	4,599	13,062			35
36	Other (specify):*											36
37	TOTAL Ownership			1,390,518	1,390,518		1,390,518	138,569	1,529,087			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		98,951	56,582	155,533		155,533	(2,131)	153,402			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		98,951	183,602	282,553		282,553	(2,131)	280,422			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,035,607	609,312	3,947,045	7,591,964		7,591,964	(224,891)	7,367,073			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(109,856)	30		9
10	Interest and Other Investment Income	(5,225)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(254)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(19,891)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,963)	20		28
29	Other-Attach Schedule	(98,935)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (334,124)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	109,233		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 109,233		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,891)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRIAR PLACE LTD.

ID# 0031765

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	COLLECTION EXP	$ (5,289)	21	1
2	BANK CHARGES	(3,496)	21	2
3	NON ALLOWABLE LEGAL	(21,773)	19	3
4	IL COUNCIL (COPE)	(2,841)	20	4
5	UNDOCUMENTED ADMIN TRAVEL	(15,178)	25	5
6	VA EXPENSE	(49,553)	10	6
7	NON-ALLOWABLE INSERVICE EXPENSE	(805)	23	7
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			5,904	(8,468)		(6,469)						(9,033)	1
2	Food Purchase	(254)		(555)			4,104						3,296	2
3	Housekeeping			2,309									2,309	3
4	Laundry													4
5	Heat and Other Utilities			3,059									3,059	5
6	Maintenance			16,949	(29,490)		1						(12,540)	6
7	Other (specify):*			2,393			211						2,604	7
8	**TOTAL General Services**	(254)		30,059	(37,959)		(2,153)						(10,306)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(49,553)		34,588	(68,385)	61,327	38	(3,895)					(25,880)	10
10a	Therapy			6,895	(4,114)								2,781	10a
11	Activities			2,670	(4,050)								(1,380)	11
12	Social Services			2,512	(7,423)								(4,911)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,933		7,723							13,656	15
16	**TOTAL Health Care and Programs**	(49,553)		52,598	(83,972)	69,050	38	(3,895)					(15,734)	16
	C. General Administration													
17	Administrative			55,629	(65,781)	65,781	100						55,729	17
18	Directors Fees													18
19	Professional Services	(21,773)		8,154	(330,519)		19						(344,119)	19
20	Fees, Subscriptions & Promotions	(26,695)		2,221	(21,170)		9						(45,635)	20
21	Clerical & General Office Expenses	(104,785)		159,540	(29,874)		176						25,057	21
22	Employee Benefits & Payroll Taxes				(31,246)								(31,246)	22
23	Inservice Training & Education	(805)											(805)	23
24	Travel and Seminar			1,616			1						1,617	24
25	Other Admin. Staff Transportation	(15,178)		87	(15,000)		203						(29,888)	25
26	Insurance-Prop.Liab.Malpractice			1,567									1,567	26
27	Other (specify):*			24,184		8,251							32,435	27
28	**TOTAL General Administration**	(169,236)		252,998	(493,590)	74,032	508						(335,288)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(219,043)		335,655	(615,521)	143,082	(1,607)	(3,895)					(361,329)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(109,856)	276,837	11,978									178,959	30
31	Amortization of Pre-Op. & Org.		1,678										1,678	31
32	Interest	(5,225)	878,018	12,536			3						885,332	32
33	Real Estate Taxes			4,439									4,439	33
34	Rent-Facility & Grounds		(942,530)	6,092									(936,438)	34
35	Rent-Equipment & Vehicles			4,588			11						4,599	35
36	Other (specify):*													36
37	TOTAL Ownership	(115,081)	214,003	39,633			14						138,569	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(394)	(1,737)					(2,131)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(394)	(1,737)					(2,131)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(334,124)	214,003	375,288	(615,521)	143,082	(1,988)	(5,632)					(224,891)	45

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				GWH LIMITED PARTNERSHIP		BUILDING
						PARTNERSHIP

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST EXPENSE	$	GWH LIMITED PARTNERSHIP	100.00%	$ 878,018	$ 878,018	1
2	V	30	DEPRECIATION EXPENSE		GWH LIMITED PARTNERSHIP	100.00%	276,837	276,837	2
3	V	31	AMORTIZATION		GWH LIMITED PARTNERSHIP	100.00%	1,678	1,678	3
4	V	34	RENTAL INCOME	942,530	GWH LIMITED PARTNERSHIP	100.00%		(942,530)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,530			$ 1,156,533	$ * 214,003	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 5,904	$ 5,904	15
16	V	2	FOOD		CARE CENTERS, INC.	100.00%	(555)	(555)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.	100.00%	2,309	2,309	17
18	V	5	UTILITIES		CARE CENTERS, INC.	100.00%	3,059	3,059	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.	100.00%	16,949	16,949	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.	100.00%	2,393	2,393	20
21	V	10	NURSING		CARE CENTERS, INC.	100.00%	34,588	34,588	21
22	V	10A	THERAPY		CARE CENTERS, INC.	100.00%	6,895	6,895	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.	100.00%	2,670	2,670	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.	100.00%	2,512	2,512	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.	100.00%	5,933	5,933	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	55,629	55,629	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.	100.00%	8,154	8,154	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.	100.00%	2,221	2,221	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.	100.00%	159,540	159,540	29
30	V	24	SEMINARS		CARE CENTERS, INC.	100.00%	1,616	1,616	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.	100.00%	87	87	31
32	V	26	INSURANCE		CARE CENTERS, INC.	100.00%	1,567	1,567	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.	100.00%	24,184	24,184	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.	100.00%	11,978	11,978	34
35	V	32	INTEREST		CARE CENTERS, INC.	100.00%	12,536	12,536	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.	100.00%	4,439	4,439	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.	100.00%	6,092	6,092	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.	100.00%	4,588	4,588	38
39	Total			$			$ 375,288	$ * 375,288	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 8,468	CARE CENTERS, INC.	100.00%	$	$ (8,468)	15
16	V	19	ACCOUNTING	21,886	CARE CENTERS, INC.	100.00%		(21,886)	16
17	V	19	ANCIL ADMIN FEE	27,840	CARE CENTERS, INC.	100.00%		(27,840)	17
18	V	19	BOOKEEPING	47,328	CARE CENTERS, INC.	100.00%		(47,328)	18
19	V	19	DATA PROCESSING	8,352	CARE CENTERS, INC.	100.00%		(8,352)	19
20	V	19	LEGAL	22,483	CARE CENTERS, INC.	100.00%		(22,483)	20
21	V	19	MANAGEMENT FEE	194,880	CARE CENTERS, INC.	100.00%		(194,880)	21
22	V	19	PROFESSIONAL FEES	7,750	CARE CENTERS, INC.	100.00%		(7,750)	22
23	V	20	ADVERTISING	21,170	CARE CENTERS, INC.	100.00%		(21,170)	23
24	V	25	REBILL BUS	15,000	CARE CENTERS, INC.	100.00%		(15,000)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	31,246	CARE CENTERS, INC.	100.00%		(31,246)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.	100.00%			27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.	100.00%			28
29	V	6	REBILL. PAYROLL MAINT.	29,490	CARE CENTERS, INC.	100.00%		(29,490)	29
30	V	10	REBILL. PAYROLL NURSING	68,385	CARE CENTERS, INC.	100.00%		(68,385)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	4,114	CARE CENTERS, INC.	100.00%		(4,114)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	4,050	CARE CENTERS, INC.	100.00%		(4,050)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	7,423	CARE CENTERS, INC.	100.00%		(7,423)	33
34	V	17	REBILL. PAYROLL ADMIN.	65,781	CARE CENTERS, INC.	100.00%		(65,781)	34
35	V	21	REBILL. PAYROLL CLERICAL	29,874	CARE CENTERS, INC.	100.00%		(29,874)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 615,521			$	$ * (615,521)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 61,327	$ 61,327	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.	100.00%	7,723	7,723	16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	65,781	65,781	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.	100.00%	8,251	8,251	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 143,082	$ * 143,082	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 2,319	$ 2,319	15
16	V	2	FOOD		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	4,104	4,104	16
17	V	6	MAINTENANCE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	17
18	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	211	211	18
19	V	10	NURSING		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	38	38	19
20	V	17	ADMINISTRATIVE		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	100	100	20
21	V	19	PROFESSIONAL FEES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	19	19	21
22	V	20	DUES, FEES, SUB.		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	9	9	22
23	V	21	CLERICAL & GENERAL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	176	176	23
24	V	24	SEMINARS		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	1	1	24
25	V	25	TRAVEL		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	203	203	25
26	V	32	INTEREST		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	3	3	26
27	V	35	RENT - EQUIPMENT & VEHICLES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	11	11	27
28	V	39	ANCILLARY ENTERAL SUPPLIES		CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	134	134	28
29	V	1	DIETARY SUPP	8,788	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(8,788)	29
30	V	39	ANCILLARY SUPP	528	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%		(528)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,317			$ 7,329	$ * (1,988)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 32,068	$ 32,068	15
16	V	39	MEDICAL SUPPLIES		XCEL MEDICAL SUPPLLY LLC		14,299	14,299	16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	35,963	XCEL MEDICAL SUPPLLY LLC	100.00%		(35,963)	19
20	V	39	MEDICAL SUPPLIES	16,036	XCEL MEDICAL SUPPLLY LLC			(16,036)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 51,999			$ 46,367	$ * (5,632)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 105,316	$ 105,316	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	105,316	CCS EMPLOYEE BENEFIT GROUP	100.00%		(105,316)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 105,316			$ 105,316	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	OWNER	Administrative	31.43%	SEE ATTACHED	2.39	3.32%		$		1
2	NOAH WOLFF	OWNER	Administrative	11.84%	SEE ATTACHED	12	28.57%				2
3	MARK STEINBERG	OWNER	Administrative	2.04%	SEE ATTACHED	2.44	4.88%	Salary Alloc	2,167	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,167		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	74,255	$ 5,904	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		74,255	(555)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	74,255	2,309	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		74,255	3,059	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	74,255	16,949	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		74,255	2,393	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	74,255	34,588	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	74,255	6,895	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	74,255	2,670	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	74,255	2,512	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		74,255	5,933	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	74,255	55,629	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		74,255	8,154	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		74,255	2,221	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	74,255	159,540	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		74,255	1,616	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		74,255	87	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		74,255	1,567	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		74,255	24,184	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		74,255	11,978	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		74,255	12,536	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		74,255	4,439	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		74,255	6,092	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		74,255	4,588	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 375,288	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296		61,327	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011			7,723	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		65,781	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			8,251	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 143,082	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,322,899	28	578,157	413,013	9,317	2,319	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,322,899	28	1,023,347		9,317	4,104	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,322,899	28	185		9,317	1	3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,322,899	28	52,590		9,317	211	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,322,899	28	9,570		9,317	38	5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,322,899	28	25,000		9,317	100	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,322,899	28	4,819		9,317	19	7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,322,899	28	2,196		9,317	9	8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,322,899	28	43,980		9,317	176	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,322,899	28	257		9,317	1	10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,322,899	28	50,512		9,317	203	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,322,899	28	801		9,317	3	12
13	35	RENT - EQUIPMENT & VEHICI	HEALTH SYSTEMS INC.	2,322,899	28	2,624		9,317	11	13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,322,899	28	33,430		9,317	134	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,827,468	$ 413,013		$ 7,329	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 32,068	1
2	39	MEDICAL SUPPLIES	DIRECT ALLOCATION						14,299	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 46,367	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 105,316	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 105,316	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	WHITE OAK NURSING CTR		X	MORTGAGE PAYABLE	$78,544	03/01/97	$ 7,441,383	$ 7,126,127	11/01/21	12.00%	$ 859,740	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DIAWA		X	WORKING CAPITAL				131,096			41,305	6
7												7
8												8
9	TOTAL Facility Related				$78,544		$ 7,441,383	$ 7,257,223			$ 901,045	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										25,592	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 25,592	14
15	TOTALS (line 9+line14)						$ 7,441,383	$ 7,257,223			$ 926,637	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	SHAREHOLDER LOAN	X					$	$			$ 18,278	1
2	ALLOC - CCI	X									12,536	2
3	ALLOC - CCI HEALTH SYS	X									3	3
4	INTEREST INCOME										(5,225)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 25,592	21

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	259,905	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	265,536	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,631	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	275,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	280,731	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	255,356	8
	1997	261,872	9
	1998	256,204	10
	1999	247,528	11
	2000	261,097	12

2001 ACCRUAL = 262000 * 1.05 = $275100

ALLOCATION FROM CARE CENTERS $4439

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIAR PLACE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-20-102-035-0000	LTC PROPERTY	$ 261,096.52	$ 261,096.52
2.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 66,986.83	$ 3,267.33
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 328,083.35	$ 264,363.85

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 11,979
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 4,753
4. Dates Incurred: _____

Nature of Costs: ORGANIZATION COSTS / FINANCING FEES
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1997	$ 402,069	1
2	CCI ALLOC			3,122	2
3	TOTALS			$ 405,191	3

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20	263	263	3,978	9
10	Various			1987	138,915		20	7,310	7,310	107,217	10
11	Various			1988	9,885		20	519	519	7,120	11
12	Various			1989	5,410		20	264	(264)	3,256	12
13	Various			1990	42,578		20	2,130	2,130	24,617	13
14	Various			1991	11,813		20	591	591	6,404	14
15	Various			1992	11,426		20	571	571	5,329	15
16	Various			1993	8,851		20	443	443	5,509	16
17	Various			1994	25,632		20	1,282	1,282	9,315	17
18	Various			1995	50,028		20	2,502	2,502	16,381	18
19	Various			1996	161,111		20	8,053	8,053	39,594	19
20	Various			1997	165,320		20	8,266	8,266	39,899	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		7,111,243	166,312		185,606	19,294	897,320	68
69	Financial Statement Depreciation			115,591			(115,591)		69
70	TOTAL (lines 4 thru 69)		$ 7,747,212	$ 281,903		$ 217,800	$ (64,631)	$ 1,165,939	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,747,212	$ 281,903		$ 217,800	$ (64,103)	$ 1,165,939	1
2	PLUMBING RENOV.	1998	1,355		20	68	68	272	2
3	PLUMBING RENOV	1998	1,907		20	95	95	372	3
4	CUBICLE CURTAINS	1998	909		20	45	45	176	4
5	FIRE ALARM UPGRADE	1998	730		20	37	37	145	5
6	PLUMBING RENOV	1998	16,500		20	825	825	3,163	6
7	HVAC RENOV	1998	11,089		20	554	554	2,124	7
8	ELECTRICAL RENOV	1998	1,891		20	95	95	364	8
9	ROOF RENOV	1998	32,500		20	1,625	1,625	6,229	9
10	FLOORING	1998	10,860		20	543	543	2,036	10
11	HVAC RENOV	1998	2,008		20	100	100	375	11
12	WALL MOUNT	1998	735		20	37	37	139	12
13	HVAC RENOV	1998	3,933		20	197	197	722	13
14	FIRE ALARM SYS	1998	2,700		20	135	135	495	14
15	ROOF RENOV.	1998	9,250		20	463	463	1,659	15
16	HVAC RENOV	1998	17,362		20	868	868	3,110	16
17	LANDSCAPING	1998	10,125		20	506	506	1,771	17
18	WINDOWS	1998	707		20	35	35	123	18
19	PIPING	1998	633		20	32	32	112	19
20	TILEING	1998	4,757		20	238	238	833	20
21	FIRE ALARM SYS	1998	27,900		20	1,395	1,395	4,883	21
22	AWNING	1998	1,891		20	95	95	325	22
23	LANDSCAPING	1998	4,054		20	203	203	677	23
24	HVAC RENOV	1998	2,225		20	111	111	370	24
25	LANDSCAPING	1998	1,361		20	68	68	221	25
26	TILING	1998	6,315		20	316	316	1,027	26
27	HVAC REPAIR	1998	775		20	39	39	127	27
28	TILE REPLACEMENT	1998	680		20	34	34	108	28
29	TILES	1998	723		20	36	36	114	29
30	HVAC REPAIR	1998	693		20	35	35	111	30
31	SPRINKLER SYSTEM	1998	1,360		20	68	68	215	31
32	NOMAI LITES	1998	805		20	40	40	160	32
33	ALARM	1998	2,026		20	101	101	328	33
34	TOTAL (lines 1 thru 33)		$ 7,927,971	$ 281,903		$ 226,839	$ (55,064)	$ 1,198,825	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,927,971	$ 281,903		$ 226,839	$ (55,064)	$ 1,198,825	1
2	ROOFING	1998	4,600		20	230	230	613	2
3	WIRING	1998	640		20	32	32	64	3
4	HINGES	1999	1,907		20	95	95	277	4
5	CORNER GUARDS	1999	891		20	45	45	128	5
6	HVAC	1999	688		20	18	18	47	6
7	RECEIVER SYSTEM	1999	2,143		20	107	107	276	7
8	SPRINKLER	1999	2,240		20	112	112	289	8
9	HVAC	1999	1,065		20	53	53	137	9
10	HVAC	1999	953		20	48	48	116	10
11	HVAC	1999	1,341		20	67	67	162	11
12	WATERPROOF SVCS	1999	900		20	45	45	109	12
13	HVAC RENOVATION	1999	658		20	33	33	77	13
14	FAUCETS	1999	1,009		20	50	50	121	14
15	POWER FOR TOASTER	1999	660		20	33	33	80	15
16	WATER HEATERS	1999	7,485		20	374	374	873	16
17	MOTOR WORK	1999	1,243		20	62	62	140	17
18	BRASS/CHROME HANDLES	1999	696		20	35	35	105	18
19	HVAC	2000	511		20	26	26	52	19
20	HVAC	2000	679		20	34	34	68	20
21	CIRCUIT BREAKERS	2000	580		20	29	29	58	21
22	BOILER REPAIRS	2000	975		20	49	49	98	22
23	HVAC	2000	1,043		20	52	52	100	23
24	PLUMBING REPAIR	2000	701		20	35	35	67	24
25	PAINTING	2000	1,286		20	64	64	123	25
26	PLUMBING REPAIR	2000	506		20	25	25	48	26
27	PLUMBING	2000	1,006		20	50	50	83	27
28	TANK & PUMP	2000	10,225		20	511	511	852	28
29	HVAC	2000	534		20	27	27	43	29
30	HVAC	2000	3,829		20	191	191	302	30
31	HVAC	2000	524		20	26	26	39	31
32	CONDENSOR	2000	505		20	25	25	38	32
33	DRAIN	2000	887		20	44	44	66	33
34	TOTAL (lines 1 thru 33)		$ 7,980,881	$ 281,903		$ 229,466	$ (52,437)	$ 1,204,476	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 7,980,881	$ 281,903		$ 229,466	$ (52,437)	$ 1,204,476	1
2	HVAC	2000	857		20	43	43	61	2
3	HVAC	2000	2,285		20	114	114	152	3
4	CONCRETE PATIO	2000	6,233		20	312	312	416	4
5	PLUMBING	2000	6,300		20	315	315	420	5
6	HVAC	2000	1,069		20	53	53	66	6
7	ELEVATOR	2000	50,875		20	2,544	2,544	3,180	7
8	WATER HEATER	2000	7,450		20	373	373	466	8
9	REWIRE SPEAKERS	2000	898		20	45	45	56	9
10	HVAC	2000	559		20	56	56	65	10
11	CUBICLE CURTAINS	2000	1,108		20	55	55	105	11
12	PLY PANELS	2000	809		20	40	40	70	12
13	LINEN CHUTE	2000	1,290		20	65	65	114	13
14	WINDOW REPAIR	2000	664		20	33	33	58	14
15	RAIN VENT CAP	2000	618		20	31	31	52	15
16	EXHAUST FAN	2000	1,900		20	95	95	158	16
17	DOORS	2000	614		20	31	31	52	17
18	DOOR	2000	827		20	41	41	65	18
19	CABINETS	2000	712		20	36	36	57	19
20	WINDOWS	2000	679		20	34	34	51	20
21	CABLE	2000	3,176		20	159	159	225	21
22	CIRCUIT	2000	2,500		20	125	125	177	22
23	DOOR CLOSER	2000	917		20	46	46	65	23
24	THERMOSTAT-ETC.	2000	1,737		20	87	87	116	24
25	FLOOD LIGHTS	2000	792		20	40	40	50	25
26	RELAY BOARD	2000	1,676		20	84	84	105	26
27	ALARM	2000	814		20	41	41	58	27
28	ELEVATOR DOOE OPENER	2000	1,185		20	59	59	84	28
29	FLOOD LIGHT	2000	510		20	26	26	35	29
30	DOOR CLOSERS	2001	565		20	57	57	57	30
31	ELEVATOR ELEC	2001	7,450		20	373	373	373	31
32	CONTROL UNIT	2001	503		20	50	50	50	32
33	CONTROL UNIT	2001	1,353		20	124	124	124	33
34	TOTAL (lines 1 thru 33)		$ 8,089,806	$ 281,903		$ 235,053	$ (46,850)	$ 1,211,659	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,089,806	$ 281,903		$ 235,053	$ (46,850)	$ 1,211,659	1
2	ANTENNAS	2001	1,340		20	123	123	123	2
3	ROOFING	2001	500		20	46	46	46	3
4	FAUCET	2001	573		20	52	52	52	4
5	HVAC	2001	1,792		20	83	83	83	5
6	DEVICE FOR ELEVATOR	2001	2,000		20	183	183	183	6
7	CABLE JACKS	2001	723		20	30	30	30	7
8	ALARM DEVICE	2001	2,475		20	207	207	207	8
9	KEYPAD	2001	685		20	58	58	58	9
10	CABINETS	2001	753		20	29	29	29	10
11	GAS HOSE	2001	543		20	20	20	20	11
12	PUMP	2001	760		20	25	25	25	12
13	PAIN	2001	789		20	23	23	23	13
14	DRIANS	2001	567		20	16	16	16	14
15	SPRINKLER HEADS	2001	1,130		20	33	33	33	15
16	MOTOR	2001	721		20	21	21	21	16
17	PAINT	2001	681		20	17	17	17	17
18	TILE	2001	1,681		20	84	84	84	18
19	PAINT	2001	1,199		20	25	25	25	19
20	PAINT	2001	1,006		20	21	21	21	20
21	ALARM REPAIR	2001	537		20	11	11	11	21
22	FIRE ALARM	2001	1,425		20	30	30	30	22
23	FIRE ALARM	2001	1,425		20	30	30	30	23
24	VALVES	2001	1,605		20	67	67	67	24
25	GAS PIPE	2001	725		20	12	12	12	25
26	PAINT	2001	1,282		20	43	43	43	26
27	ID CONSOLE	2001	676		20	23	23	23	27
28	FIRE ALARM	2001	1,425		20	24	24	24	28
29	PLUMBING	2001	660		20	8	8	8	29
30	TILING	2001	4,172		20	52	52	52	30
31	PLUMBING	2001	509		20	6	6	6	31
32	PLUMBING	2001	643		20	8	8	8	32
33	MASONRY	2001	3,000		20	25	25	25	33
34	TOTAL (lines 1 thru 33)		$ 8,127,808	$ 281,903		$ 236,488	$ (45,415)	$ 1,213,094	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,127,808	$ 281,903		$ 236,488	$ (45,415)	$ 1,213,094	1
2	HAND RAIL	2001	1,624		20	14	14	14	2
3	EJECTOR PUMP	2001	3,275		20	27	27	27	3
4	CODE ALERT	2001	(1,676)		20	(14)	(14)	(14)	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,131,031	$ 281,903		$ 236,515	$ (45,388)	$ 1,213,121	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1997		$ 7,041,541	$ 164,470	39	$ 183,266	$ 18,796	$ 885,786	4
5					55,245	1,417	35	1,578	161	8,024	5
6											6
7											7
8											8
	Improvement Type**										
9	CARE CENTERS INC.			2001	157	21	20	4	(17)	4	9
10	CARE CENTERS INC.			2000	67	2	20	3	1	6	10
11	CARE CENTERS INC.			1999	989	25	20	50	25	143	11
12	CARE CENTERS INC.			1998	408	10	20	20	(10)	75	12
13	CARE CENTERS INC.			1997	5,795	102	20	320	218	1,868	13
14	CARE CENTERS INC.			1996	6,369	84	20	336	252	1,319	14
15	CARE CENTERS INC.			1997	672	156	20	29	(127)	95	15
16	CARE CENTERS INC.			1994		19	20		(19)		16
17	CARE CENTERS INC.			1993		6	20		(6)		17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,111,243	$ 166,312		$ 185,606	$ 19,274	$ 897,320	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,190,241	$ 117,941	$ 51,469	$ (66,472)	10	$ 297,086	71
72	Current Year Purchases	35,802	474	1,983	1,509	10	1,983	72
73	Fully Depreciated Assets	128,494				10	128,494	73
74								74
75	TOTALS	$ 1,354,537	$ 118,415	$ 53,452	$ (64,963)		$ 427,563	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1993 FORD VAN	1993	$ 47,239	$ 2,143	$ 3,453	$ 1,310	5	$ 40,298	76
77	FACILITY	CHICAGO BUS SALES	2001	4,439	888	259	(629)	5	259	77
78	FACILITY	TAIL PIPE	2001	1,154	231	38	(193)	5	38	78
79	FACILITY	CCI ALLOCATION		26,714	4,088	4,095	7	5	13,180	79
80	TOTALS			$ 79,546	$ 7,350	$ 7,845	$ 495		$ 53,775	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,970,305	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 407,668	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 297,812	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (109,856)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,694,459	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		232		$			3
4	Additions							4
5	ALLOCATED FROM CCI				6,092			5
6								6
7	TOTAL		232		$ 6,092 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 13,062 Description: SEE ATTACHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 19,316	$		$ 19,316	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,631			6,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			30,635			30,635	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				64,580		64,580	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						34,371		34,371	13
14	TOTAL			$		$ 56,582	$ 98,951		$ 155,533	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,226	$ 1,226	1
2	Cash-Patient Deposits	77,347	77,347	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,062,163	1,062,163	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	333,756	333,756	6
7	Other Prepaid Expenses	11,069	11,069	7
8	Accounts Receivable (owners or related parties)	(6,327)		8
9	Other(specify): See supplemental schedule	170,668	170,668	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,649,902	$ 1,656,229	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	949,088	949,088	15
16	Equipment, at Historical Cost	851,151	2,076,151	16
17	Accumulated Depreciation (book methods)	(856,314)	(2,588,483)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	3,588	11,979	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,075)	(11,186)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 944,438	$ 7,253,932	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,594,340	$ 8,910,161	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,105,208	$ 1,304,213	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	75,262	75,262	28
29	Short-Term Notes Payable	131,096	131,096	29
30	Accrued Salaries Payable	255,837	255,837	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,501	22,501	31
32	Accrued Real Estate Taxes(Sch.IX-B)	275,100	275,100	32
33	Accrued Interest Payable		72,177	33
34	Deferred Compensation	1,370	1,370	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,866,374	$ 2,137,556	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		7,126,127	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 7,126,127	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,866,374	$ 9,263,683	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 727,966	$ (353,522)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,594,340	$ 8,910,161	48

*(See instructions.)

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 275,839	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 275,839	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	462,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(10,300)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 452,127	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 727,966	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,024,252	1
2	Discounts and Allowances for all Levels	(418,114)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,606,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	277,745	6
7	Oxygen	4,647	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 282,392	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	115,460	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,613	19
20	Radiology and X-Ray	1,960	20
21	Other Medical Services	37,603	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 160,636	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,225	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,225	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,054,391	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,572,375	31
32	Health Care	2,454,533	32
33	General Administration	1,891,985	33
	B. Capital Expense		
34	Ownership	1,390,518	34
	C. Ancillary Expense		
35	Special Cost Centers	155,533	35
36	Provider Participation Fee	127,020	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,591,964	40
41	**Income before Income Taxes (line 30 minus line 40)****	462,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 462,427	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,936	2,161	56,670	26.22	2
3	Registered Nurses	17,853	20,816	456,542	21.93	3
4	Licensed Practical Nurses	20,654	24,198	480,300	19.85	4
5	Nurse Aides & Orderlies	72,095	85,213	763,543	8.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,917	4,446	53,659	12.07	8
9	Activity Director	1,944	2,088	26,718	12.80	9
10	Activity Assistants	10,887	11,718	87,436	7.46	10
11	Social Service Workers	10,554	11,551	152,400	13.19	11
12	Dietician					12
13	Food Service Supervisor	3,542	4,082	61,972	15.18	13
14	Head Cook	5,852	6,752	78,043	11.56	14
15	Cook Helpers/Assistants	21,439	24,015	168,886	7.03	15
16	Dishwashers					16
17	Maintenance Workers	11,169	13,899	157,364	11.32	17
18	Housekeepers	23,434	24,994	189,580	7.59	18
19	Laundry	12,737	13,775	116,650	8.47	19
20	Administrator					20
21	Assistant Administrator	1,166	1,469	27,629	18.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,800	10,113	126,333	12.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,985	2,241	31,882	14.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	229,964	263,531	$ 3,035,607 *	$ 11.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	549	$ 22,098	01-03	35
36	Medical Director	MONTHLY	9,000	09-03	36
37	Medical Records Consultant	MONTHLY	1,702	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	3,130	10-03	39
40	Physical Therapy Consultant	237	11,871	10a-03	40
41	Occupational Therapy Consultant	61	3,045	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	495	10a-03	43
44	Activity Consultant	53	2,316	11-03	44
45	Social Service Consultant	MONTHLY			45
46	Other(specify)				46
47	CCI - Costs (See Attached Schedule		83,972	VARIOUS	47
48	Utilization Review Committee	MONTHLY	75	10-03	48
49	TOTAL (lines 35 - 48)	910	$ 137,704		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	473	$ 20,357	10-03	50
51	Licensed Practical Nurses	1,871	59,875	10-03	51
52	Nurse Aides	1,976	39,518	10-03	52
53	TOTAL (lines 50 - 52)	4,320	$ 119,750		53

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrator Salary directly allocated from home office			$
(See P. 6B)			
KRISTEN ZALESKI	ASST. ADMINISTRATOR		27,629
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 27,629

B. Administrative - Other

Description	Amount
CCI - ADMINISTRATIVE PAYROLL	$ 65,781
TOTAL (agree to Schedule V, line 17, col. 3)	$ 65,781
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FROST, RUTTENBERG AND		$
ROTHBLATT	ACCOUNTING	25,475
CARE CENTERS	ACCOUNTING	21,886
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	2,327
CARE CENTERS	ANCILLARY ADMIN SERV	27,840
CARE CENTERS	HOME OFFCIE EXP	194,880
CARE CENTERS	BOOKKEEPING	47,328
CARE CENTERS	LEGAL	22,483
CARE CENTERS	PROF. FEES	7,750
SEE ATTACHED SCHEDULE	DATA PROCESSING	15,149
SEE ATTACHED SCHEDULE	OTHER PROFESSIONAL	4,900
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 370,018

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 151,000
Unemployment Compensation Insurance	34,503
FICA Taxes	232,224
Employee Health Insurance	165,532
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PENSION EXP	3,953
EMP PHYSICALS	3,117
MISC EMP. WELFARE	10,398
DRUG SCREENING	1,520
TOTAL (agree to Schedule V, line 22, col.8)	$ 602,247

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	35,175
Health Care Worker Background Check	
(Indicate # of checks performed 127)	1,524
ADVERTISING	19,891
LICENSES AND PERMITS	26,647
SUBSCRIPTIONS	12,347
ALLOC CCI	2,221
ALLOC CCI - HEALTH SYS.	9
Less: Public Relations Expense	(19,891)
Non-allowable advertising	
Yellow page advertising	(3,963)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 74,160

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,269
ALLOC CCI	1,616
ALLOC CCI - HEALTH SYSTEMS	1
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,886

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRIAR PLACE LTD. # 0031765 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL $ 9392

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,071 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 127,020
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees